Information Exchange Workgroup
Draft Transcript
October 14, 2010

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Good afternoon, everybody, and welcome to the HIT Policy Committee's Information Exchange Workgroup. As a federal advisory committee, there will be opportunity at the end of the call for the public to make comments. Just a reminder for workgroup members to please identify yourselves when speaking. Let me do a quick roll call. Micky Tripathi?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
David Lansky? David is going to be in and out a little bit. He's in a cab. Judy Faulkner? Carl Dvorak?

Carl Dvorak – Epic Systems – EVP
Carl Dvorak on for Judy and Carl.

Judy Sparrow – Office of the National Coordinator – Executive Director
Gayle Harrell? Michael Klag? Deven McGraw? Latanya Sweeney? Charles Kennedy?

Charles Kennedy – WellPoint – VP for Health IT
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Paul Egerman?

Paul Egerman – Software Entrepreneur
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Jim Golden? Dave Goetz?

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Jonah Frohlich?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Steve Stack? George Hripcsak? Seth Foldy? Jim Buehler?

Jim Buehler – CDC – Acting Director, Public Health Surveillance Program Office
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Walter Suarez?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
David Ross? Hunt Blair? George Oestreich? Donna Frescatore? Jess Kahn? Claudia Williams?

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Tim Andrews?

Tim Andrews
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Kory Mertz?

Kory Mertz – NCSL – Policy Associate
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Did I leave anyone off?

David Lansky – Pacific Business Group on Health – President & CEO
Judy, it's David Lansky. I just got on.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you. I'll turn it over to Micky Tripathi.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Welcome, everyone, to the Information Exchange Workgroup. I would just want to welcome also David Lansky, our co-chair. Today we're going to be focused on provider directories and talking about, for the last few weeks we have been focused on the question of provider directories, how they contribute to health information exchange, and what policy actions the government might be able to take to help facilitate the creation of or creation in making themselves provider directories that will help accelerate secure and safe and high quality health information exchange into the near future here, particularly to support meaningful use, as well as transactions beyond that.

I'm going to turn it over to the co-chairs of our Provider Directory Taskforce, Jonah Frohlich and Walter Suarez, in a second. Just to provide a little bit of context, we will be making recommendations on principles, on the principles that we are going to use in our deliberations going forward with respect to provider directories, and that's what we're going to be discussing today. We will be making the recommendations on principles to the Health IT Policy Committee next week on the 20th, so this was the opportunity for the workgroup to review and discuss and modify the principles that the taskforce has been working on and is now putting forward for workgroup deliberations.

In terms of the roadmap, the idea is that we will sort of stage our recommendations on directories through the rest of this calendar year with an eye toward the principles for the October policy committee meeting and then, for November and December, sequentially thinking about what we're loosely calling entity level directories, which would have more of a focus on facilitating exchange across clinical entities, perhaps with sort of a nationwide perspective in mind, so being able to have that facilitate nationwide capabilities and have some conformance across the country, as it relates to an entity level directory. Then we'll move in December to a set of recommendations about how that could be the basis for a state level or sub-national level directories, I should say, that would have sort of a mapping back or the ability to interoperate with that entity level directory, but allowing some variation at the sub-national level related to

further levels of granularity, perhaps at the clinician level or with other types of information to facilitate different sets of activities that might be contemplated at the level lower than the national level. That would be for a set of recommendations for the December policy committee meeting.

But we're focused now on principles. We're going to focus on the principles themselves in this workgroup call. There is, for the policy committee meeting itself, we'll provide a little bit of background context and some slides related to that that we've talked about at the taskforce level, but we didn't want to have those be a part of this conversation because we didn't want to get caught up on background slides and really wanted to have all of us have a more deep conversation and thoughtful conversation about the principles themselves. I just wanted to inform the workgroup that when you see the policy committee meeting, you may see some background slides, which are really just about background and context, but not about the principles themselves.

With that as introduction, let me first off thank Walter and Jonah for all of the hard work and the leadership on this taskforce because it's quite a complicated issue with many, many dimensions. I really appreciate their diligence and their perseverance and their leadership in moving us forward in this.

Let me turn it over to Jonah and Walter now.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Walter, I don't think you and I have really discussed how we were going to divvy up the slides, so if you have any thoughts about how you want to proceed.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Let me just say a couple of words, and I'll turn it to you since you have some time constraints that I want to make sure that you cover the contents of the slides. The only thing I wanted to say, I guess, as part of this stage is in order to get certainly to the principles, we also want to make sure that we all understand what is it that we're trying to address, what's the problem we're trying to solve, and what is the gap or gaps that exist. Those two are very, very important in order to set the stage for the principles that we will be presenting and discussing. Then, in the later stages, really talk about the elements of the recommendations now drilling down into the relevant or the recommendations regarding the relevance of this NPT level directory.

Today we want to, since basically we have a little bit more time in this call, we want to spend time insuring that we come out with the principles and consensus around the principles, but we also have a good sense and understanding of the problems we're trying to address and the scope of this gap that we are trying to … with an NPT level directory. So I just wanted to mention that, and I think we only have about nine slides, so hopefully we will be able to make sure that everybody is in agreement and there's consensus around the problem statements and the gaps and the scope of the recommendation that we will be discussing in more detail later on in October, November, and December. But as stage two, get to the principles, I think, is going to be important to do that.

I'll turn it to you, Jonah, and you can walk us through the slides.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
I think saying that the issues around the directory are complicated is kind of like saying save, secure, health information exchange is hard to do. We spent a great deal of time in our workgroup having very lively discussions about what exactly it is we mean when we say provider directory, and what is it that provider directories are intended really to facilitate. What was our problem that we were trying to solve, and are the use cases? We're going to walk through that.

We're going to walk through some of the issues that really helped formulate our thinking. What we're going to do today, we're going to just describe the goal, what is the goal of sort of the program goal or the policy goals and objectives. What is the specific problem we're trying to address? So some use case definitions, so it's really clear how the provider directories themselves are intended to be used or what exactly they are. Then define high-level key principles, which we've just described as a main objective for

today's group. We want to present to you, as a workgroup, some of our proposed principles and get your feedback and input, and make sure that we're on the mark. We've also, as we've done, as we've really considered what some of the other taskforces and workgroups have done, specifically work around the tiger team and some work around NHIN Direct, so we've had quite a bit of conversation about those two specific initiatives and incorporated some of the thinking into some of these recommendations for principles.

If we go to the next slide ….

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Jonah, just a quick note for whoever is driving the WebEx, I'm still seeing the first slide, so I don't know if it's moving or it's a refresh issue or what. For those that are on the WebEx, I think we're not seeing ….

M
No. I'm seeing it. I'm on slide three.

Judy Sparrow – Office of the National Coordinator – Executive Director
It's moved. We're on three.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
So it's just my problem then. Sorry. Go ahead.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
As co-chair of the committee, hopefully we can resolve that. That's kind of important. Background, we're not going to spend much time on this, but this helps set the context for what the directory issue is about.

As you all know, we still are engaging in a great deal of exchange of health information. It happens frequently, but it typically happens through non-electronic means. We don't count fax or phone as electronic in this case or mail, and it does happen through a variety of channels, whether it's a proprietary channel, SureScripts, Quest Diagnostics with EHR vendor networks or others like health information exchange organizations. It happens.

What directories are about is, in this case, as we've described them, they map what we call human friendly information into machine-readable information. The example that you can think of is an IP address is a bunch of digits and dots, but we don't memorize digits and dots. We memorize the departmentofhealthandhumanservices.gov Web site. We know that. Behind the scenes, a directory will translate that human readable, understandable information into the dots and digits that are required for transporting information. This plays a critical role. These directories play a critical role in making exchange easier, more scaleable in a whole host of other contexts, like I just mentioned for Internet protocol.

Most proprietary's today are proprietary and local. They're specific to specific mode of exchange, so they really are focused on performing a set of tasks or supporting a set of activities. It might be, and we're heard from a number of organizations, Intermountain, for example, on our workgroup and in testimony that they have a provider directory and many other organizations have those. They're internal to within organizations. They're contact lists. They're directories of individuals, locations, in some cases entities. So that's one form of directories.

There are others that are network specific directories. We've heard, again, from SureScripts at the hearing about the directory that they support and the way they do it with identifiers that are internal to SureScripts. Then the most well-known non-proprietary cross-organizational directories are those distributed by DNS registries. You can think of VeriSign and others who do this and manage the whole registration process for domain names.

Health information exchange, particularly directed exchange transactions, and when we mean directed, we're really talking about sort of push messaging from one endpoint to another. We'll continue to grow

regardless of what we do, whether or not there are federal or state government actions in the form of statute, regulation, or guidance. Whether or not any of those actions are taken on provider directories, we're going to continue to see exchange happen and grow. But our objective is really to see it happen much more quickly in a safe, secure way, in a way that facilitates transport of information within a region, within a state, across state lines, and across the country, and the premise being that provider directories can support this.

We see a variety of exchange approaches likely to be available to clinicians using these newly certified EHR services and systems entering the market and the meaningful use incentives kick in. So there is a market force here that's going to see different exchange patterns emerge. That's natural whenever markets are growing. However, adoption speed likely will be hindered by, as I mentioned, a lack of some sort of uniformity or ubiquitous approach to having cross-enterprise and cross-platform directed exchange. So if there was some uniformity, and that doesn't necessarily … one single monolith, a national directory, it could be a pattern or a set of common requirements that allow for some straightforward federation.

There could be a few different ways of thinking about this that we, as a workgroup, are going to be thinking about in terms of the recommendations we make. Then access to provider directories can play a key role in making exchange more uniform and usable from a user perspective. Before I move on, does anybody have any questions about the background? I think it's pretty straightforward.

Charles Kennedy – WellPoint – VP for Health IT
Just being a health insurance guy on the phone, any particular reason we didn't include any of the administrative clearinghouses? Is that just kind of out of bounds?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
No. It was really only by example, so whether or not we're considering Emdeon or some of the work that CAQH has done. Those are all part of the pantheon of directories, so this was really only by example and not meant to be universal.

Charles Kennedy – WellPoint – VP for Health IT
Okay.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Let's move to slide four, please. This led us to making sure that we had a specific problem and policy objective we wanted to address, and a problem statement, and a set of key questions, many of which we pose to our invited participants in the hearing. Our policy objective, as we stated here, is to facilitate rapid increase in secure, electronic, health information exchange throughout our health system. This is really in alignment with the goals of HITECH and really, to that extent as well, goals of federal health reform.

The problem statement here, as we describe it, is that there's a lack of a consistent approach to cross-organizational provider directories, and that this will be a barrier to progress, both in directed exchange and in health information exchange more broadly and other exchange patterns. It also represents a missed opportunity to combine multiple streams of funding, and we're thinking both in terms of incentives paid to physicians and hospitals and clinicians in terms of the grants that are being made or the HIE cooperative agreement programs and others that will yield a lower cost and a higher quality service for all. There's really a government sort of sponsored market opportunity to think about how we can support and accelerate directed exchange and health information exchange more broadly by establishing some uniformity around provider directories.

The key questions that this workgroup will address include how can provider directories accelerate health information exchange safe and securely? What can federal and state governments do to guide directory development to support meaningful use and drive system-wide improvements of care? We should be thinking about the financial means of driving that development, policy, and regulatory. What policy actions can be taken to promote creation of provider directories that accelerate secure information

exchange? How can health information exchange across state borders nationwide be accelerated by a consistent application and use of provider directories?

Is that clear so far? This is really the framing for the work that we intend to do in the directory taskforce.

George Oestreich – Missouri Medicaid – Deputy Division Dir., Clinical Services
Yes. I think I would call out Medicaid in the 90/10 funding a little more explicitly. I think it's a significant driver.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Absolutely. I think it is a good point that we should, as a workgroup, enumerate what some of those funding opportunities are, whether it's 90/10, whether it's the incentives themselves whether it's the HIE cooperative agreement program.

George Oestreich – Missouri Medicaid – Deputy Division Dir., Clinical Services
Right.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Beacon, etc., and in developing a national level repository or registry for incentives themselves. I think it's a good point. We should probably think about how we can enumerate those funding sources and try to quantify just the scale that we're talking about here.

We can move to slide five. Walter, if at any point in time you want to jump in, let me know. Okay?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Sure. No. Go ahead. You're on a roll.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
We had a hearing on September 30th. It was in Washington, D.C. It, at one point, rained in the room, which was an interesting distraction. What we did is we had four panels. Two were on business requirements, so we had two panels, one representing broadly providers, and the second health plans and public health and others. State and regional framing was a third where we also had some public health and state testimony. Then the fourth was technical requirements. We wanted to lead with the business, basically stating what it is that provider directories can and should do to support business process, and then go towards the state funding, which is the state and regional framing, which included things like what are the opportunities that are being funded today that can drive directory adoption and use. Then go to the technical requirements, what are the technical requirements that the business use cases or the business case is driving.

A number of common themes really emerged. There wasn't a whole lot of conflict or conflicting testimony, so there were a number of themes that emerged. One is that the first priority of the work should really focus on a thin layer of discoverability for what we called entity level directories. This is specifically not at a clinician level, which is important, but a second order issue. What that means is we should really be focusing on the sort of organization-to-organization exchange. It's basically exchanging data to the front door, and we should not concern ourselves that much at this point yet as to how we direct exchange to the providers within the boundaries of that organization.

We needed to first establish a priority around sort of that organization-to-organization exchange. The way we framed it was we used something called a yellow pages for the provider directory, and we ended up confusing people. But what we did instead, and it emerges a theme, as you'll see later in the slide, is that it's still important to be able to look up where an individual clinician may reside. But then for machine-to-machine transactions, it's more important that we focus on the entity and the communication between those entities and those source systems.

The three key components to focus on with this in mind with the thin layer of discoverability was defining standards, addressing schemas, establishing basic discoverability of the entity, the IP address, and the

services that are supported by that entity, whether or not they can consume a C32 or an HL-7 document, and establishing basic discoverability of entity security credentials. Those are the three key components of the thin layer discoverability.

The common requirements for these entity level directory services should be defined at a national level, so there should be a thin, core level of requirements that should be adhered to at a national level that would enable federation or some way of working collaboratively with what's in existence today in the market and what might emerge. That these directories need to support interoperability across state lines and regions and should leverage the work, as I just mentioned, that's in the market today. So there shouldn't be a rip and replace methodology. There are some very successful local and regional and sub-national initiatives and some national that can really be leveraged effectively, we believe, and that's what we heard from the testimony.

We need to align with meaningful use stage one transaction needs, but want to insure, with the recommendations that emerge, that we really carefully consider the implications of stage two and three, even though we don't completely know them. But we should try to anticipate what those needs are and beyond what might be needed for health reform and other things that we might not be able to envision. That calls for a certain level of rigidity, but also a certain level of flexibility, which is a nuance, but important.

Then we should consider the role of NHIN Direct. What is NHIN Direct doing? What does it need? What other things is it not doing that a provider directory kind of service could support?

The second thing was on the clinician discoverability. What we had initially called and are moving away from the sort of yellow pages function. This is more of the human interaction when a primary care physician doesn't know where a specialist may be practicing for a patient who makes a request for a referral. There may be a need. The premise was, and we heard this generally from the testimony, a need for the humans to be able to look up and identify where that clinician practices so that when the EHR system is sending a patient visit summary or a patient history to that provider, it knows where that provider's source system is. It knows what entity that provider lives in.

We heard clearly from many people that this is a very important function, but that it isn't necessarily embedded within the entity directory. It complements and can support and really supports the human interaction need to make sure that the document gets to where it should go.

What we heard is that it should be defined at an individual clinician level. That the development and implementation could be at a regional or state level, and that we don't need the same kind of rigid conformance that is likely needed for the entity directory requirements. So far, is it clear, and did I misstate anything for those who either participated in the panel or are on the workgroup?

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I think this is excellent. I just wanted to go to the last point. One of the things people brought up in the hearing is the possible need for another layer of double-checking, that someone is, for instance, a licensed clinician, and that they're alive, and that they have a valid license. So while I don't think that suggests rigid conformance, as we get into that area later, it may suggest. It's part of what we're trying to do with … another layer of trust, another layer of, I believe I'm sending it to the right person and that they're a valid person to send it to. We may get into issues around it's comprehensive, it's been validated, and stuff like that. So I don't think that's exactly conformance, but it may actually have another set of more stringent demands if we're going to use it for certain purposes.

Sorin Davis – CAQH – Managing Director, Universal Provider Data Source (UPD)
Claudia, are you referencing, for instance, verifying that the clinician is actually licensed or their specialty is what they claim to be, or are you talking about some other level of identification?

Claudia Williams – ONC – Acting Director, Office State & Community Programs

I'm not talking about authentication in a computer-to-computer sense, and we're going to get into this later, so we don't need to address it now, but just one of the things people talked about is being a good value from the … level thing is another way to say, yes, that person is a specialist. They do have a license, and it's one more sort of double-check before I press send. As we get into that conversation in probably a month, we'll just need to really think about what we're trying to achieve with that kind of directory.

Sorin Davis – CAQH – Managing Director, Universal Provider Data Source (UPD)
Okay. Thank you.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Good question. That was the kind of issue that we fell into a trap of trying to address directly before we got to some of the higher level needs of framing the issues. It's something that we struggle with a lot in our deliberations. Slide six, please. Any other thoughts on the hearing or feedback, comments?

Paul Egerman – Software Entrepreneur
I was just going to say, I thought you did an excellent job.

Charles Kennedy – WellPoint – VP for Health IT
So a physician solo practice would be an entity?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Yes. Thank you, Paul, by the way. I appreciate that, and I compliment the work of ONC and my co-chair and Micky and David. The notion would be that a small fellow doctor practices in a legal organization that is his or her practice. That practice would be the entity, the destination for a message.

Charles Kennedy – WellPoint – VP for Health IT
Okay. When I grab something like, let's say I know a physician is on staff at a large, integrated, delivery system. We are relying on the internal provider directory of that entity to then route it to the individual doctor, right?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Right. There are a set of rules that each one of those kinds of organizations has, and those rules may be rules on call or how people cover or whether or not somebody has come or gone, and it has to be resolved to the patient level. So if that patient was assigned to a provider who is no longer there, that organization needs to insure that the message gets to the new provider. Yes, that's one of the reasons why it was really clear from testimony that, from many, that if we start to get into the doorway of the organizations, there's a nest of issues that is probably beyond scope at this point.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes. Let me point out one thing here. I think one of the types of messages is certainly going to be someone sending something to a specific provider, specific physician within a specific organization. But as I think Jonah will be describing in the use cases, in many cases also the exchange, and this is the primary focus of our attention is really going to be an organization like a hospital sending a discharge summary to a doctor, but it's really to the organization where that doctor works and … patient.

So it's that message in the … possibilities will come from that hospital to the provider organization, and the content of the message, the discharge summary itself will be posted basically into the electronic health record as soon as the discharge message, for example, comes in the CDA or CCD or CCR standard and is received. The electronic health record system captures it and then incorporates that into the appropriate record of that person in the electronic health record system itself. When the provider that the message is intended to will be able to open that person's electronic health record and see the discharge summary. That type of a workflow process and that type of a message exchange process is one that would be supported by this type of entity level directory.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

Yes. Thank you. That's a really helpful clarification. Slide six, the priority, this is the use case that we're proposing here. Understand that what we're saying here is that there should be priority given to provider directories that first support meaningful use stage one transactions, and again, we have to make sure that what we recommend is able to accommodate to the extent that we know and anticipate what can happen in later stages. But the three directed exchange transactions, again because directed exchange is what is included in stage one meaningful use, here are, from a PCP to and from a specialist, and again, basically, as Walter said, problem list, patient visit summary, a host of types of information that would be exchanged between those two clinician types, and that's not the universe, but this is what we're just stating for this use case.

The second is the ambulatory physician to and from a hospital, whether it is a patient history, a discharge summary, an emergency department visit summary or surgical report, again, not necessarily the universe of the kinds of transactions, but an example. Finally, the ambulatory physician to and from a laboratory, a lab order, a lab result. We're not necessarily stating here that e-prescribing will not be facilitated, would not necessarily be supported by a directory. We're just limiting right now the use cases to three areas where we think there's the most value in making recommendations given that the infrastructure for e-prescribing is perhaps in some ways a little more mature. Before I move on, I want to make sure everyone is comfortable with the use cases because that's kind of driving. It's going to drive much of our recommendation in the future.

Jim Buehler – CDC – Acting Director, Public Health Surveillance Program Office
Was there consideration of a use case that would focus on the population health measures and the connection between the clinician or the hospital to public health departments?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Not explicitly here, but we did hear testimony about the need for that, both from Missouri and Minnesota in their comments and from CDC. What I think we should probably do is describe it. There are directed exchange requirements that can support public health and population health reporting. I think that's right. Micky, Walter, do you have any?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I think that is a very important one to consider. It opens up, of course, the question about who is to be going into the provider directories. I mean certainly public health agencies as one of the recipients of these messages would need to be included, and we're not saying that they won't be included. But I think that will be a question that will come up when we begin to dive deep into the content and the participants and all the elements of the provider directory. But I think we should certainly have in mind that since we are looking at meaningful use as stage one of one of the expected elements that we will fulfill with this. So I'd like to … thank you for that.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Yes.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes. I agree. Thank you, Jim.

George Oestreich – Missouri Medicaid – Deputy Division Dir., Clinical Services
As long as you're going to go down that pathway, maybe would also want to consider the sustainability issues associated with using it as access to licensure and qualification for the incentives. We've envisioned using it as a primary provider database that would also have qualification/disqualification information. Maybe group it with other nonspecific healthcare exchange functional use in the context of increased utilization and sustainability. Is that too far out?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
George, I think it might be for this stage because I think what we're trying to focus on is directed exchange at the entity level right now.

George Oestreich – Missouri Medicaid – Deputy Division Dir., Clinical Services
Okay.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
I think what you mentioned is important for us to consider in the provider, that provider directory recommendations that would be coming later. But I think it's a good point that we need to consider as we're making some of those other recommendations with the clinician level directory, I should say. Excuse me.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes. I think this is the additional type of information that needs to get into more of the yellow page application, if you remember that concept, which we're not using anymore, but it really is the kind of additional information that a provider directory can provide certainly beyond the specific functional capability of being able to route or to allow exchange of information.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Can I just pile on some … comments about this? What I think is really a wonderful step forward for this work is the clarity and discipline around starting with principles that can form the basis of both the two phases, entity and clinician level. I think also, to the extent feasible, keeping the conversation focused on the stage you're in kind of, but maybe we can find a way to parking lot things that we need, okay, that's a stage two issue. I really like the way you've laid this out, and I think it helps us and the taskforce level have—we've had a really rich conversation, and I think we're going to move into an even more disciplined mode where we can kind of have a trajectory and stick with it, but be sure we're capturing the ideas that we need to consider later on. We can, certainly at the ONC level, as we're taking notes and so forth, kind of help both with the discipline and with the making sure we're not losing ideas, even if we can't address them right now.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Thank you. It's reassuring, I've got to say. Two overarching problems to solve for directed exchange and meaningful use stage one. We had quite a bit of discussion about these two, so it's interesting to hear feedback, or maybe not and just get right into the principles. The two overarching problems: one we characterize as discovery and what we mean by that is the need to know what messages the recipients are able to consume: CCD, lab result, HL-7, etc.; what mode of communication to use, and how to identify both the correct recipient and their address for any given mode. What we suggest here is that this specific set of problems around discovery are those that can be directly addressed by provider directories. So the directory can really help any of those who are sending a message to a recipient, to an entity, whether or not that entity can consumer a C32, whether or not it is going to the right recipient, and what address it is, what right Internet address it is and where it lives.

The second overarching problem around security, authentication, and there's a need to verify that the recipient computer has appropriate security credentials, and the second is on transport. I need to have a secure means of transporting that message. This we characterize as being supported by provider directories, but not necessarily directly addressable to them. I think we call to mind issues that are happening now. One example is NHIN Direct where they're developing the transport protocols for the demonstration project. We do not anticipate that the directories are going to be addressing the transport protocol issue, but they can support it because they can help define or the would help specify the endpoint, the IP address of the entities that the transport protocols need to send the message two.

Before I move on, I'm going to throw caution to the wind. Does this characterization of the two overarching problems and whether we've addressed them appropriately with what directories can directly impact or support? Does this seem right to people?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I just want to make a quick clarification point. In the credentials side, there are really two elements of it. One is that the discovery of the credential and the other one is the verification of the credential, which is really part of the authentication. I just want to make sure that in the discovery part, people also

understand that there is this need to discover the credential of a recipient, a security credential of a recipient. That discovery element is a component of what the directories can certainly address. The actual authentication, the actual verification of that credential and validation of the credential is part of the security element, the authentication process that is not part of the provider directory itself, but is supported certainly by the provider directory. So I wanted to make that distinction in the credentials.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Yes. Excellent point. Other thoughts from members of the workgroup, does this characterization, this framing appear right to everybody?

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I think it looks great.

Hunt Blair – OVHA – Deputy Director
Yes, Jonah. I think you've done a masterful job of distilling down many hours into a good, solid, area.

Deven McGraw – Center for Democracy & Technology – Director
I think it looks great, Jonah and Walter. Good job.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
We're very fortunate to be supported by excellent people, Micky included, Claudia, Kory, and others. So we're very fortunate to be able to work with them and produce this. Let me just say it wasn't easy.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I just wanted to say, I think the members of the taskforce—Paul, Carl, and others—were instrumental certainly in giving shape to this. I have to say personally, I joined this group thinking well this will be an easy one. I have spent more time on this particular workgroup and taskforce probably than any other one, but it's been just terrific, so I really appreciate everybody's input on this.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Here, here. I was similarly deceived. Let's go to the principles. You should all know that Walter is going to be taking over exclusively in about ten minutes because I have to join another call. We are going to be moving to slide seven. Excellent.

These are the high level principles to consider from the nationwide framework. We've broken this, I think, down into two areas. One is we reviewed the nationwide framework principles. These were also included in the tiger team recommendations, and called out from those, and we took from those the principles that we believe applied to what we think should be our considerations for recommendations. There are five of them that we believed directly applied to our decision-making here, and these are the five. They're taken verbatim. We didn't try to tweak them so that they were specific to directories, so they might be a little awkward, but I want to just run them by you and read them to you, and then get your comments and your thoughts.

The first is around open and transparency, openness, and that there should be an openness and transparency about all of these procedures and technologies that directly affect individuals and their individually identifiable health information. The applicability to provider directories is that the directory policies, procedures, and technologies should be open and transparent. That was our thinking.

The second is around collection, use, and disclosure limitation that individually identifiable health information should be collected, sent, used, and/or disclosed only to the extent necessary to accomplish a specified purpose or purposes, and never to discriminate inappropriately. Again, the applicability to the directory conversation is that the directories will support the exchange, collection, and disclosure of health information in a consistent and reliable manner. They will be a vehicle by which this information is collected, used, and disclosed.

The third is on data quality and integrity, that person and entities should take reasonable steps to insure that individually identifiable health information is complete, accurate, and up to date to the extent necessary for the persons or entities intended purposes, and not been altered or destroyed in an unauthorized manner. The applicability again to the directory conversation is by supporting reliable information exchange in real time. Provider directories will help insure that complete and accurate data is available to support delivery of care. It's, again, intended to support the notion that we need good, comprehensive, and complete data to make decisions.

The fourth is around safeguards. Individually identifiable health information should be protected with reasonable administrative, technical, and physical safeguards to insure its confidentiality, integrity, and availability and to prevent unauthorized or inappropriate access, use, or disclosures. The applicability to the directories is that the provider directories will support secure exchange of health information. We're going to see another security principle on the next page, so we may want to think about how these things relate.

Then the fifth, finally, accountability that these principles should be implemented and adherence assured for appropriate monitoring and other means and methods should be in place to report and mitigate nonadherence and breaches. So obviously what this means is that a provider directory context is that directories will help insure accountability of those involved in information exchange. I think what that means is you have to have a reasonable amount of assurance that those people listed in the directories have passed basic levels of accountability, and that if they are not able to consistently that there needs to be some sort of a recourse about their ability to participate in a directory.

This is a slide from the principles from the nationwide framework. I want to hear from you all about whether or not these are appropriate, whether or not there's feeling that these potentially should be altered in some way to support more directly our provider directory recommendations.

Deven McGraw – Center for Democracy & Technology – Director
I think I initially when I saw the application of the nationwide framework principles, which are really more directly about the exchange of protected health information or patient identifiable data, I think initially I thought, well, wait a minute. We're talking about provider directories here, right? They are geared towards the sharing of PHI, but there's not PHI in the directories. But in essence, it actually, I thought the application of those principles, not withstanding that it's maybe not a perfect fit, came out. You ended up with a good set of principles from them. While admittedly at first I was like, what are they doing here? I think we will have to be careful in case people might misunderstand what we're doing here to be careful that we're not actually taking about nesting PHI within a provider directory.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
That's an excellent point.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
The nationwide framework was put out a couple years ago by ONC and really relied on fair information practice principles as the basis for these domains, along with a couple of others. What's interesting is, to your point, Deven, I mean obviously the most common use of those is around PHI and so forth. But they're used broadly outside the healthcare, within the healthcare as ways to think about information sharing and being sure it's trusted.

I think we may want to actually more explicitly talk about the information in a provider directory. For instance, we may want to say there should be explicit policies about who is authorized to use and in what manner the provider directory under, for instance, either an openness and transparency or use. There are a couple of places where I think we could more explicitly call out how these apply to the actual use of the directory itself. I think we'll get to some of that in the questions in the last slide, but I do think we would like for folks who have directories to be very clear about what they're being used for and why, and how that links back to some of these other concepts of generating trust and being open and being secure.

David Lansky – Pacific Business Group on Health – President & CEO

I want to build on these last couple comments, and maybe you can summarize the state of our discussion with regards to the criteria for including an entity in the directory as the extent to which it has to attest or demonstrate its ability to enforce policies internally. One of my concerns, I understand the reason for focusing the broader directory on the entity level and not the individual practitioner level. But essentially you're asking an entity to guarantee a set of practices. The … fair information practices through its internal mechanisms, which are invisible to us. Where do you think we're at with whether we will create a set of criteria requirements for entity …?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
What I believe we could and should do is we should apply these principles to our formulation of a set of recommendations that states what we think are the minimum requirements for entities and insuring that those who are part of that entity, those clinicians, follow these rules, and probably that a set of fair information practices are applied. I think what we can do is instead of doing some of that de novo, we simply point to some of the recommendations that are being made and, at least ONC, I think, has approved, like the tiger team recommendations. But that they point to a set of fair information practices instead of supporting something that we create, something new.

David Lansky – Pacific Business Group on Health – President & CEO
I guess I'm getting at the idea of whether the contemplation is or isn't that there would be a kind of, in effect, attestation or a contract that says if I'm sending a message to a provider in Arizona, I need to know that the Arizona directory … speaks for the entities in its directory, which I know nothing at all about. The same standard, or at least an understandable standard of assurance has my own directory in California and New York. Creating transparency around that level of assurance seems like an implication of this last principle.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Yes.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes. I just wanted to mention that, as Jonah has pointed out, these principles are sort of the overarching, high-level principles. As we get down into the discussion of the policy and functional elements of the directories, one of the specific questions is the requirements to participate in the conformance and update and accuracy of the information that participants will be expected to provide and maintain. I think that will link back directly to the principles of accountability and data quality.

David Lansky – Pacific Business Group on Health – President & CEO
Yes. I guess what I'm saying is one of our principles in affect is these are transited principles. But if they apply or get delegated down through the ranks, then we expect the same level of conformity to these principles at the highest level, as well as at the more granular levels.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Yes.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
David, I think one of the issues that you're getting at here, and I think is going to be a part of our future conversations is who would these principles apply to, and sort of by what authority—I'll put that in quotes—would they sort of be deemed to be subject to these principles? Let me just put it that way. I don't mean it to sound pictorial. But the providers, there are lots of directories that serve a wide variety of functions, and it's not clear that every directory needs to follow these principles or would be required to. Some might be voluntary adherence. Some might be being able to use different levels to government policy and funding that could get adherence to something.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
This is reminding me of, I think, what's being considered in the tiger team in the following way. I think the question and, Deven, you can correct me, but I think the question what was asked is what will be the necessary approach, let's say, to consent, to assure trusted information sharing. That was asked first.

Then the second set of questions is around how to do you achieve that and what are the levers and so forth.

I'm wondering if we could apply a similar to these kinds of what do we think is needed and then what are the opportunities to achieve that. We may determine that it's voluntary, you know, good citizen, or we may determine that a bunch of things are in the market and will evolve quickly. But, Deven, I wonder if you could speak a little bit to why you—that's how you approach things, I think, as a tiger team, and I think there was some … provided to figure figuring out what was needed and then sort of figuring out how to get there.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
What I think where we ended up is in coming to the conclusions about how are we really scoping our discussion and our set of recommendations, focusing on the entity. I'm not sure we've totally resolved the issue about who the principles apply to. I think, more specifically, the question that David raised, which is really important, which is, how are we—are we making recommendations? Are we going to make recommendations in this team that there should be a minimum set of requirements that providers, entities, I should say entities, anywhere in the country adhere to with respect to basic understanding about minimum necessary, use and disclosures, etc. Is that the kind of recommendation we're going to make?

I don't think we're resolved that, quite frankly. I think these principles are supposed to be applied to our decision-making so that we can frame our recommendations. We can refer back to them when we make our recommendations, refer back to our principles and say this is the justification behind this recommendation. But I'm not sure we've really resolved the issue that David brought up, which is, how broadly are these recommendations intended to apply?

Paul Egerman – Software Entrepreneur
Let me try to respond a little bit, and also, I'll do my best to respond to, I think, what you're asking, Claudia. In the tiger team, it is the case that we just did our best to focus entirely on a set of principles and sort of like what is the basic requirements. What are we trying to do? That helped us. That discipline helped us make progress. One way to look at the issues that David is raising is to say those are, in some sense, governance issues. In other words, what do you do if you set a bunch of policies and somebody doesn't follow it? What do you do if it's followed one way in Arizona and a different way in California? My response to that is simply to say, well, that's a very good question. We do have a governance team, but just besides the fact of having a governance team, I'd say it's a good question. That's why this is such an interesting topic.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Yes. With that, I'm really sorry that I have to leave at this point, but you're in good hands with Walter, Micky, and David. Thank you, and I apologize.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Thanks, Jonah. Thank you. Just to continue that, you're absolutely right, Paul. I think this set of principles helped us guide and help us frame the recommendations. The expectation is that they're not, at this point yet because we haven't defined all of those elements within the actual entity level directory, and then later on, any other directory that we make recommendations on. We haven't yet, of course, mapped each of these principles back to the recommendations. I think that will be a helpful exercise once we dive into the discussions of the actual entity level directories, for example, and then, again, bring those back, those recommendations back to these principles to make sure that they map.

Are there any other comments or questions about this high level set of principles or the mapping that we're doing at this point to the applicability to provider directories? If not, let's move to the next slide, and this is really at the heart of the discussion for today. This is the set of principles that we are recommending to present to the policy committee to guide the development of our provider directory policy level of recommendations.

Besides the ones that we just talked about, which are the higher level, overarching reference principles, these are more specific to the development of the provider directory policy recommendations. These are, as you can see here, not exclusive or specific to the level of granularity of the directory. In other words, this doesn't just apply to the entity level directory. This applies to just our guiding principles to the development of all policy recommendations and provider directories. With that, let me just go through those, and we'll certainly have a chance to have more significant discussions on all of them.

The first one is business processes. We have heard, and consistently understood from the recommendations coming out of the hearing that we should start simple and with what's really needed to support the basic priority business process that we need to support, and not really with the specific data elements or data content. So we're going to start from that side and business processes and these workflows are the most critical piece of what needs to be supported by these provider directories, so that's what is going to be really driving our policy recommendation and not the data itself. That's the first principle.

The second one, which you've heard of quite consistently throughout is to focus with the principle meaningful use, which is focused on requirements for stage one at this point, but certainly not … inside of stage two and stage three in general because, of course, we don't know the details of stage two or state three. But we do know that the progression from stage one to stage two to stage three is really to increase and enhance the functionality of the information exchanges and the capabilities of that. In order to do that, we need a robust provider directory, so that's a meaningful use principle.

The third one is the principle of agility. Really not over-designing at this early stage, but remaining flexible to be able to allow changes in technology and business processes to be accounted for. For example, the accountable care organization initiatives and efforts that are going to be coming out, and any other reform initiatives that exist already in the Accountable Care Act, plus any other changes certainly in technology, we will be mindful and be able to be flexible to adapt to those. That's the principle agility that we'll use in defining the policy recommendations.

Incremental, this is a very important one because this helps us define the scope really in many respects of the work we're going to be doing, so we'll start with identifying and clearly define and articulating the minimum set of the directory functional capabilities. What is this directory? What is it that it's going to fulfill in terms of capabilities? Then discuss and delineate some of the most straightforward, technical ways, models that are needed to help us accelerate and enhance the secure exchange of information. This is, again, in support of meaningful use. This particular incremental principle is really going to help us focus on the directory capabilities and make sure that both directory capabilities and the technical models will help us fulfill the goals of meeting meaningful use and responding to business process needs.

Then we have a principle of collaboration. Basically certainly we want to make sure that as the development of this entity level directory and, farther down the road, other directories are going to continue to … regional and multistate and national initiatives that are leveraging purchasing, policy, and regulatory opportunities. I think, throughout the discussion today, we've talked about all the incentives and levers that we are going to be looking for to help encourage all these initiatives to support this provider directory implementation and adoption. We mentioned it's going to be very helpful to delineate some of those levers from incentives, investment perspective, from a purchasing policy, regulatory perspective, one of those levers.

The principle completeness clearly identifying who are the sources of the information, who are the users, and what are the uses that will be supported by these provider directories. Then the principle of security, just building off on the overarching principle we talked in the previous slide, insuring that protected health information will be transmitted in a secure manner, but also assuring that the actors are participating in that exchange to adhere to the minimum set of standards that allow the protection of that information. That's another guiding principle that we will be using in developing the policy recommendations. Those were basically our seven guiding principles that are specific again to the development of the provider directory.

It's certainly not well, and we didn't do this, but I think it will be easy to map these principles back to our overarching principles in the previous slide. But this one is now focused specifically on the development of the policy recommendations. Let me stop there and see if there are any questions or comments or additional principles that we should consider.

Jim Buehler – CDC – Acting Director, Public Health Surveillance Program Office
I think this is an excellent list. I think this, and the previous set of principles, have utility beyond just your team.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Thanks. Do people feel comfortable with these principles and sensing here that there is full consensus that these will be our guiding principles?

Hunt Blair – OVHA – Deputy Director
I certainly support them.

David Lansky – Pacific Business Group on Health – President & CEO
Sounds like your good, Walter.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I have to say again, like Jonah and Micky mentioned, this has been an evolutionary process. There's been really a lot of refinement on all this, so we appreciate everybody's input on this. Claudia, were you going to say something?

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I had two thoughts. One is that these are interestingly reminiscent of the principles that were used to guide the implementations workgroup last when Aneesh Chopra ran that. Just the idea of kind of focusing on a real problem and being as simple as you can be and being with an eye to the future. Anyway, I'm almost curious to map them back.

The other thing is that I think, in this kind of work, once you dig into the work itself, you will sometimes uncover new principles, so we may just want to say that this is our going forward set of principles, and it's going to guide our work, but we may uncover some new … as we go along, so we just may want to stay open to that and, by the way, to incorporate those insights, as we move through the work.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes. Thank you, Claudia, for that. Yes, absolutely, I think we will need to be mindful and flexible of what other principles we really need to consider and build into this list, as we begin to get into the details of the directories. Yes. Thank you, everyone, again. This has been great to reach this level of consensus around this. Again, the main purpose of our call today was to get us to this point. I do want to go to the next slide because this next slide really is going to be an important slide to set the stage for the next steps, so if you can take us to the next slide.

The last slide in the deck basically starts to identify some of the questions that the workgroup will get into in the next session. Now here you can begin to see some of the details, so I want to spend a few minutes here. One element that is certainly not here in the slide is the fact that we will be developing sort of a terminology reference document, basically making sure that when we say provider directories, people understand what that is. When we say provider, the people know what that means. When we say end node or routing or all these terms that we will be now getting into to use to describe the functional capabilities of the directories, will be clearly understood. Terminology will be one of the important elements in the next steps.

But in terms of the other areas, we group them into two main areas. First of all, functionality, we need to describe and document what is the functional capabilities, again, of the directory. Then the other group is policy, and we have a whole host of elements there. At the bottom of the slide, you'll see a little section that says standards. Really what that's meant to do is to create the hook back to the HIT Standards

Committee because, at the end of the process, I think the policy recommendations that we will be providing will be sort of the guardrails, the guiding elements for the HIT Standards Committee to look into the standards that need to be identified, vetted, and recommended to support provider directories functionality, as described in the policy recommendations would provide. Those are the sort of areas that we will be talking about next.

In terms of functionality, basically three important elements: the scope, what is really in scope. We have now the reference documents that we just talked about, and so that part is going to be certainly part of the discussion again moving forward, making sure that we retain the focus, flexible to understand some of these other elements that we've talked during the call today, and see what other … issues might come up. The other question related to functionality are certainly the functional areas to be supported, so we identify those three areas of these, and so we'll dive deep into more specifically what they mean.

The intent today is certainly not to answer all these questions, but just to highlight the topics, if you will, that we'll be getting into in the next phase of our work. The functional areas will include things like certainly … exchanging, exchanges both in terms of routing, as well as query and retrieval capabilities, supporting this basic discoverability element that we talked about earlier.

Then the third element in the functionality is really how to operationalize all these functional areas that we will be talking about. How to operationalize a thin layer discoverability, entity discoverability capability, the certificate entities, certificate discoverability. How are the services really going to be managed to build, develop, implemented? All these elements are some of the things that we will need to get into, in the next phases of our discussion.

Those are functionality type of questions. I'm sure there are a lot more questions around it. Then the policy questions really focus around four major areas. The participants, which are the entities intended to be participants that we included in these directories. We need to describe the entity type, the characteristics, the participants in specific exchange types, director, exchange of other mechanisms. The roles, what is the role of the federal government. That's one of the key questions. The concepts around building and maintaining, defining the standards, and then what is the role certainly of state and regional HIEs. Here we can certainly also identify what are the roles of other groups, other entities like the roles of the participants, the roles of the users.

The other element in the policy side is the approaches. Certainly talk about how the—one of the technical approaches that can be implemented to fulfill these entry-level directories. So we've talked about the national, centralized model, the federated model, probably hybrid models, those kinds of issues. Those are going to be the next stage of discussions.

Then in the last one on the policy side, certainly the basic participating policies, one of the requirements again that the participants will be expected to abide to in order to participate, conformance expectations, expectations about maintenance and updating and providing accurate data. Other questions like should entities be required to agree to a set of basic policies before being able to be a part of the directories? What would those policies be? Then what level of conformance and accuracies is going to be expected? Probably what are some of the enforcement, if you will, policies that would exist to management and to maintain these entity level directories?

As I think Micky and David and others have pointed out, who is this going to really apply to, and how is it going to be applied to them, if you will, in terms of what are kind of the levers and enforceability of some of these recommendations. Then, like I mentioned, the standards part, which is what standards need to be established by the HIT Standards Committee … data elements, open interfaces, and other types of standards that would be the purview of the HIT Standards Committee.

Again, this was intended to be more of, I guess, a guiding post, if you will, or opening stage for the next step that we will be taking. Again, I'm sure there will be a lot more questions that we will be adding, but I wanted to stop here and see if there's any comments or any reactions to this set of questions and any

additional important points to be made about the questions we will need to address in the coming steps. Any comments, reactions, additional questions?

Paul Egerman – Software Entrepreneur
I think you've done a very good job of laying out the questions. I had a reaction when I first read this, Walter, which you responded to when you talked about it. Because the question where it said roles, it says what is the role of state regional HIEs. When you walked us through this, you indicated it wasn't limited to those HIEs. It includes providers, who knows, maybe vendors, other groups. So I would just encourage you to put that, to add to that list there on the slide. State regional HIEs, providers, put in two or three things, maybe write, comma, etc.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Absolutely. Yes. I think, Paul, as I was reading this slide and then the list and the sort of discussion that we had, I thought it would be important to make sure that we include them as well, so certainly we will be adding that in the list ….

Paul Egerman – Software Entrepreneur
Yes … put in a couple others and like etc. or something to make sure it's not just HIEs.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes.

Paul Egerman – Software Entrepreneur
But other than that, I think it's good.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Any other comments?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
I know you're heard it, Walter. This is Steve Stack to say thank you again. This has been a kind of complex and sort of in the weeds topic for some of the provider directory stuff, and I think all today have done a fantastic job distilling it, so thank you very much.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Thank you. Thank you, Steve, for that. Yes, it has been much more complex than probably any of us thought, but it's been incredibly helpful to have the many perspectives join in the discussion and have the technical understanding of efforts like NHIN Direct and how they're addressing some of these and the support from people like certainly the team and Claudia and everybody else has been just fabulous. So I think this is truly a reflection of a team effort that we have put in here.

I think we certainly run out of slides. We thought nine slides would probably keep us busy for the two hours, but these slides have kept us busy for the last two weeks fully, or two months probably more actually. I think I'm going to stop here and turn it back to Micky to close off and to have any other topics to be covered during the call here of the Information Exchange Workgroup. Micky, back to you.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Thanks, Walter. First off, again, just want to thank all the members of the taskforce and particularly Walter and Jonah for all the time spent on this in helping lead us through these issues. Let me just ask Judy Sparrow for a little bit of direction on when we're going to need the presentation for the policy committee.

Judy Sparrow – Office of the National Coordinator – Executive Director
I would love to have them by next Monday, which is the 18th. Does that give you enough time?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I think I heard her say that Tuesday she needs the presentations.

Judy Sparrow – Office of the National Coordinator – Executive Director
Did I say that?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
We can work towards that.

Judy Sparrow – Office of the National Coordinator – Executive Director
Or even Tuesday morning would be great.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay. Tuesday morning is fantastic. What we'll do is we will take the comments that we got here, and I think it's a couple of things that you'll see in the presentation, the final presentation for the policy committee will be, as I said before, maybe a couple more background slides … contacts that we didn't go through here, but the taskforce has been through I think a little bit of mapping of the two lists of principles that we have that both Jonah and Walter referred to that there's some mapping and consolidation that we could do to better organize the principles, to not change the principles, but just organize them. Then we will circulate that back to the workgroup for any final thoughts that you have now that you've been through sort of the idea, and are able to then maybe spend a little bit of time looking it over with an eye towards getting the final comments back.

We'll set a timeline of by midday Monday or something like that just so that we can turn it around with any changes you have and get it to Judy for the policy committee. If that work okay for everyone as a process, I would just open it up to any other questions or comments that anyone from the workgroup has. If there are none, we can turn it over to Judy for the public comments. Any questions or comments from the workgroup members?

Judy Sparrow – Office of the National Coordinator – Executive Director
Operator, can you see if there's any comment from the public, please?

Operator
We do not have any comments at this time.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you, operator. Thank you, everybody.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Great. Thank you, everybody.

Judy Sparrow – Office of the National Coordinator – Executive Director
Bye-bye.

M
Thank you.

Judy Sparrow – Office of the National Coordinator – Executive Director
Bye.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Bye-bye.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Thank you. Bye-bye.

Public Comment Received During the Meeting

1. I listened to the testimony and there was, in fact, a distinct rejection of "yellow pages" and an emphasis on "routing". The routing needs of org to org routing have been define in the NHIN Exchange. Why are those not being considered here?